Early and Periodic Screening Diagnosis and Treatment
TRACKING FORM
BY 1 MONTH

TO BE FILLED IN BY OFFICE STAFF:

Last Name	First Name	AHCCCS ID	D.O.B.	Age

Primary Care Provider	Date of Examination	Health Plan Name

Birth Wt.	Weight	Percentile	Height	Percentile	Head Circumference	Percentile

TO BE FILLED IN BY PROVIDER

HISTORY INITIAL/INTERVAL

Was history form completed? [ ] Yes [ ] No

Was Hepatitis B given in the hospital? [ ] Yes [ ] No

NUTRITIONAL ASSESSMENT [ ] Breast Feeding [ ] Formula (type) _____

Supplements: [ ] Fluoride [ ] Vitamins [ ] Iron

SENSORY ASSESSMENT Vision: Within normal limits? [ ] Yes [ ] No, Refer

Hearing: Within normal limits? [ ] Yes [ ] No, Refer

DEVELOPMENTAL ASSESSMENT Age appropriate? [ ] Yes [ ] No

Responds to sounds, responds to parent's face and voice, follows with eyes.

(If suspicious, do specific objective testing) Assessment Tool (name) _____

PHYSICAL EXAM

Are the following normal?

	Yes	No
Skin		
Head		
Eyes (red reflex)		
Ears (symmetrical)		
Nose		
Mouth/Throat		
Nodes		
Heart		
Lungs		
Abdomen		
Fem. Pulse		
Ext. Gen.		
Hip Abduc.		
Extremities		
Spine		
Neuro		
Other		

LAB/SCREENING

Hct./Hgb.		

COMMENTS, ASSESSMENT & PLAN

Follow-up needed? [ ] Yes [ ] No

IMMUNIZATION ASSESSMENT

Did this child receive all immunizations due today? [ ] Yes [ ] No

Is there a current immunization record in the medical chart? [ ] Yes [ ] No

ANTICIPATORY GUIDANCE

[ ] Injury prevention
[ ] Sleep practices
[ ] Sleep positioning
[ ] Bladder and bowel habits
[ ] Nutrition
[ ] Infant Development
[ ] Time to call the doctor
[ ] Infant care
[ ] Plans for next visit

REFERRALS

[ ] CRS
[ ] WIC
[ ] Specialty _____
[ ] Other

Next scheduled visit	Clinician Name	Clinician Signature

Was this claim coded as an EPSDT Visit (HCFA-1500)? [ ] Yes [ ] No